AMENDED IN SENATE MAY 18, 1999

AMENDED IN SENATE APRIL 28, 1999

AMENDED IN SENATE MARCH 25, 1999

SENATE BILL No. 59

Introduced by Senators Perata and Ortiz
(Principal coauthor: Assembly Member Thomson)
(Coauthor: Assembly Member Alquist)

December 7, 1998

An act to add Section 1363.51 to the Health and Safety Code, to add Section 10123.135 to the Insurance Code, and to add Section 14087.41 to the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 59, as amended, Perata. Health care coverage.

(1) Existing law provides for the regulation of health care service plans by the Department of Corporations and for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan to disclose the process used by the plan to authorize or deny health care services, to the Commissioner of Corporations, health care providers under contract with the plan, and enrollees, as specified. Existing law requires a health care service plan and a disability insurer to include within its disclosure form and evidence or certificate of coverage a statement describing how participation may affect the choice of physicians. Existing law provides that a willful violation of provisions regulating health care service plans is a crime.

This bill would enact additional provisions applicable to a health care service plan that prospectively or concurrently reviews and approves, modifies, or denies, based on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to enrollees. It would require that those decisions be made within specified timeframes. These provisions would not apply to certain decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion. The bill would also enact similar provisions applicable to a disability insurer that prospectively or concurrently reviews and approves, modifies, or denies, based on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to insureds. It would require that those decisions be made within specified timeframes. Because a violation of the bill's requirements with respect to health care service plans would be a crime, this bill would create a state-mandated local program by creating a new crime.

This bill would also make legislative findings and declarations in this regard.

(2) Existing law provides for the Medi-Cal program to provide health coverage for low-income persons.

This bill would require the State Department of Health Services to develop a simple form to be used by Medi-Cal managed care plans in order to notify an enrollee of a denial, termination, delay, or reduction in benefits, as specified.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Consumers have the right to receive quality medical care in a timely and efficient manner.

(2) Decisions about medical care should be made by physicians and other relevant health care professionals.

(3) Consumers have the right to know how and why a decision about their medical care is made.

(b) ''Utilization review,'' otherwise known as ''internal review,'' is the process by which health care service plans and disability insurers review, and approve, modify, or deny, requests for treatment of patients by physicians, and the Legislature recognizes that it is an integral component of the total process by which consumers access health care services.

SEC. 2. It is the intent of the Legislature to establish sound consumer protections applicable to the internal review processes of health care service plans and disability insurers, with the goal of providing faster, more accessible, and better quality medical care to patients, with these consumer protections to include all of the following:

(a) A guaranteed time limit on the internal review process for requested health care services, not to exceed 72 hours for urgent health care service requests and five days for other requests.

(b) Physician oversight of the internal review process for requested health care services, or oversight by a licensed health care professional with relevant expertise.

(c) Denial of care only when supported by clinical criteria and only when the denial is approved by physicians or other licensed health care professionals with relevant expertise.

SEC. 3. Section 1363.51 is added to the Health and Safety Code, to read:

1363.51. (a) Every health care service plan that prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical

necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to enrollees, or that delegates these functions to contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity or appropriateness of proposed health care services are supported by criteria developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, or denies requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be filed with the commissioner for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the commissioner to the public upon request.

(c) Every health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider’s request, pursuant to subdivision

(b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity or appropriateness. In cases in which the request by a provider for authorization of health care services for an enrollee is not approved by the individual reviewing the request, the request shall be reviewed, based on clinical criteria, by a physician who holds a current, unrestricted license to practice medicine in one or more states of the United States, or by a licensed health care professional who is competent to evaluate the specific clinical issues involved in the service requested by the provider. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) If the health care service plan uses clinical criteria to determine whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, the criteria shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination. ~~The plan shall reimburse providers for the reasonable cost of medical record duplication.~~

(h) In determining whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, based in whole or in part on medical necessity or appropriateness, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until

the enrollee's treating provider has been notified of the plan's decision.

(4) Communications regarding decisions to approve requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall specify the specific health care service approved. Responses regarding decisions to deny or modify health care services requested by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be communicated to the enrollee in writing and to providers initially by telephone and then in writing, and shall include a clear and concise explanation of the reasons for the plan's response, describe the criteria used and the clinical reasons for the decisions regarding medical necessity or appropriateness. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations

or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) Except as specified in paragraph (5), a plan's failure to meet the timeframes specified in paragraph (1) or (2), whichever applies, shall be deemed to be an authorization to the provider to proceed with the requested health care services. Prior to proceeding with the service that is deemed to be authorized, the provider shall notify the plan within one business day to: (A) confirm that the timeframe has expired, (B) provide enrollee identification, and (C) provide notification of the place of service and of the provider or providers performing the service or services. The plan shall provide the provider with an acknowledgment of that notification within one business day of receiving it.

For purposes of this paragraph, the provision of health care services that are deemed to be authorized shall not create any basis of liability against the plan, provided the plan does not specify or direct the duration or manner in which the health care services were provided.

(i) Every health care service plan subject to this section shall maintain telephone access during normal business hours for providers to request authorization for health care services.

(j) Every health care service plan subject to this section that reviews requests by providers prior to, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting

providers, and provisions for evaluation of any corrective action plan and measurements of performance.

The commissioner shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(k) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270, or in any way interfere with provisions set forth in Sections 2063 and 2731 of the Business and Professions Code.

(l) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 4. Section 10123.135 is added to the Insurance Code, to read:

10123.135. (a) Every disability insurer that covers hospital, medical, or surgical expenses and that prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to insureds, or that delegates these functions to contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section shall have written policies and procedures establishing the process by which the insurer prospectively or concurrently reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on medical necessity or appropriateness of a proposed health care service are

supported by criteria developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer reviews and approves, modifies, or denies requests by providers prior to, or concurrent with, the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed to insureds and providers upon request, and by the commissioner to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Act, or the insurer may employ a clinical director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer reviews and approves, modifies, or denies, based in whole or in part on medical necessity or appropriateness, requests by providers prior to, or concurrent with, the provision of health care services to insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer to review requests by providers, approve the provider's request for authorization, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services

for an insured for reasons of medical necessity or appropriateness. In cases in which the request by a provider for authorization of health care services for an insured is not approved by the individual reviewing the request, the request shall be reviewed, based on clinical criteria, by a physician who holds a current, unrestricted license to practice medicine in one or more states of the United States, or by a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider. The decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) If an insurer subject to this section uses clinical criteria to determine whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds, the criteria shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be developed using sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least once annually.

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer shall request only the information reasonably necessary to make the ~~determination. The insurer shall reimburse providers for the reasonable cost of medical record duplication.~~ *determination.*

(h) In determining whether to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds, based in whole or in part on medical necessity or appropriateness, every insurer subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity or appropriateness, requests by

providers prior to, or concurrent with, the provision of health care services to insureds that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured's condition, not to exceed five business days from the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(2) When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, decisions regarding medical necessity or appropriateness pursuant to this section shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours of the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured's treating physician within 24 hours, decisions resulting in denial or modification of all or part of the requested health care service shall be communicated to the insured in writing within two business days of the decision. In the case of concurrent review, health care services shall not be discontinued until the insured's treating provider has been notified of the insurer's decision.

(4) Communications regarding decisions to approve requests by providers prior to, or concurrent with, the provision of health care services to insureds, shall specify the specific health care service approved. Responses regarding decisions to deny or modify health care

services requested by providers prior to, or concurrent with, the provision of health care services to insureds, shall be communicated to insureds in writing and may be communicated to providers initially by telephone but shall thereafter be communicated in writing, shall include a clear and concise explanation of the reasons for the insurer's response, and shall describe the criteria used and the clinical reasons for the decisions regarding medical necessity or appropriateness. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 7 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, then the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examination or test required. Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) Except as specified in paragraph (5), an insurer's failure to meet the timeframes specified in paragraph (1)

or (2), whichever applies, shall be deemed to be an authorization to the provider to proceed with the requested health care services, which shall be deemed to be a medically necessary or appropriate service for a requested health care service as required in the policy. All other terms and conditions of the policy shall apply. Prior to proceeding with the authorized service, the provider shall notify the insurer within one business day to: (A) confirm that the timeframe has expired, (B) provide insured identification, and (C) provide notification of the place of service and of the provider or providers performing service or services. The insurer shall provide the provider with an acknowledgment of that notification within one business day of receiving it.

For purposes of this paragraph, the provision of health care services that are deemed to be authorized shall not create any basis of liability against the insurer, provided the insurer does not specify or direct the duration or manner in which the health care services were provided.

(i) Every insurer subject to this section shall maintain telephone access during normal business hours for providers to request authorization for health care services.

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 5. Section 14087.41 is added to the Welfare and Institutions Code, to read:

14087.41. The department shall develop a simple form, consistent with the notice requirements of Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations, for Medi-Cal managed care plans to use to notify a Medi-Cal enrollee of a denial, termination, delay, or reduction in benefits. The department shall require all Medi-Cal managed care plans to use the form as a condition of participation in Medi-Cal managed care

pursuant to any contract negotiated after the effective date of this section.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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